FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: State of Washington
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

_____

(Signature of Agency Head)

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

Based on the Office of Financial Management's 1998 Washington State Population Survey (WSPS), it is estimated that about 125,000 (7.8%) of the state's children were uninsured at the date (March/April 1998) of the survey (see Attachment 1). Approximately 14,300 (8.2%) of the 175,800 children in households with incomes between 200% and 250% of the federal poverty level (FPL) would have been eligible for CHIP coverage. The state's children population increased about 1.5% between the WSPS survey and the start of Washington's CHIP in February 2000. Using this adjustment factor, we estimate there are about 14,500 uninsured CHIP eligible children at the start of Washington's program.

This estimate is higher than the estimated 10,000 uninsured CHIP eligible children submitted in Washington's June 29, 1999, CHIP State Plan application. The June 1999 data was based on an earlier release of the 1998 WSPS data. The reason these estimates differ is that the earlier version of the 1998 WSPS understated the total number of children in the state by about 88,000, due to weighting factors used in the survey sample data to project total population estimates. The CHIP baseline estimate of 14,500 is based on a revised July 1999 release of the WSPS data, which corrects for this weighting factor and includes other adjustments for missing data.

Washington did not submit a 1998 annual report because its CHIP State Plan approval was not obtained until September 1999, and the program did not start to enroll children until February 1, 2000.

1.1.1 What are the data source(s) and methodology used to make this estimate?

Washington has used its biennial WSPS survey to make its baseline estimates. We will use this source to measure subsequent changes in the number and percentage of children who have insurance coverage over time. Attachment 2 is an OFM document, titled "*1998 Washington State Population Survey Data Report*", which describes the 1998 WSPS.

It should be noted that the WSPS is conducted every two years. Thus, as described in the Washington State CHIP Plan, we will report our performance measures on the number and percentage of uninsured children on a two-year reporting cycle.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Washington is using the WSPS for its estimates because it provides more accurate data than the annual U.S. Bureau of the Census' March Current Population Survey (CPS). Based on state comparison of CPS data with two Robert Woods Johnson Foundation (RWJF) financed state surveys conducted by RAND, the CPS data over counted the number and percentage of Washington children who were uninsured. In part, this is due to the CPS stratified sample design used to make national projections. The Bureau of the Census is well aware of this matter, and annually cautions users about using changes in counts from one year to another. Such changes are often not statistically significant, particularly for smaller states with stratified samples designed for national projections, and not for individual states.

In contrast, WSPS is specifically designed to provide a profile every two years of Washington's residents between the decennial censuses. The sample included a second sample of minority populations to allow for use of data to make inferences about characteristics of all major population groups. It also results in more accurate counts of these populations, which tend to have a higher percentage of households with low-income children. Although the survey is a telephone survey, census data indicates that less than 4% of Washington residents do not have telephones.

The "*1998 Washington State Population Survey Data Report*" (Attachment 2) describes some of the limitations with the survey. Although there is an over sampling of minority populations, we have concerns about the under-reporting of certain groups of children who reside in households with a higher percentage of farm income. These groups would tend to have a higher migratory working population who are not accessible through telephone surveys. However, it may be that the children of Washington residents who are migrant workers stay at a permanent household location while their family members move about during harvest seasons.

Of more general concern is the under-counting of children and household members who are enrolled in Medicaid, or other state financed programs. The CPS is widely believed to undercount Medicaid enrollment and therefore to overstate the number of uninsured persons, including children.[1] OFM has confirmed that this under accounting applies to the 1998 WSPS, as well as the state CPS estimates. Although Washington's CHIP coverage is for families with incomes above Medicaid eligibility, we may find a similar problem in tracking children's insurance status in the 200% to 250% FPL range.

[1] See Lewis, K., M. Ellwood, and J.L. Czalka, "*Counting the Uninsured: A Review of the Literature*", Washington D.C., The Urban Institute (1998), and Frank Ullman, Brian Bruen, John Holahan, "*The Children's Health Insurance Program: A Look at the Numbers*", Occasional Paper Number 4, The Urban Institute ((March 1998).

We will be able to provide various confidence intervals based on specified margins of error (e.g., statistical confidence level). For example, the 95% confidence internal for the question "do you have Medicaid coverage" was +/-.7% of the 4.4% who said "yes".

Of more importance than the confidence intervals themselves, Washington will conduct statistical analysis of the WSPS data for each report period to determine if the computed sample point estimates are significantly different over time. We also will provide the respective range of the confidence interval estimates for the point in time measures.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

Washington's CHIP started on February 1, 2000. On February 17, 2000, the governor had a press conference to launch our "Healthy Kids Now!" marketing and outreach campaign. Healthy Kid's Now! is designed to reach and enroll all children who are eligible for, but not enrolled in, Medicaid and CHIP. This campaign's kickoff resulted in the largest one-day response to an outreach effort that our outreach contractors have ever experienced.

As of this report's date, we have approximately 101 children who have been found eligible for CHIP. We do not have information on the results of the anti-crowd-out, outreach or other efforts because the program is too new to yield meaningful data.

1.2.1 What are the data source(s) and methodology used to make this estimate?

We will use OFM's Washington State Population Survey (WSPS), along with our own data sources to estimate the number of children enrolled in Medicaid and CHIP.

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The state's assessment of the reliability of the WSPS data is discussed in Section 1.1.2 (above).

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, and denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
To increase the number of low-income children in households below 200% of FPL who have health insurance coverage.	Increase the **number** of children below 200% FPL, who have health coverage. [1]	Data Sources: Washington State Population Survey (WSPS). It is conducted every two years by the Office of Financial Management's (OFM) Forecasting section). Methodology: Compare the number of children with health insurance in 1998, to those had insurance in 2000. To estimate the number of children with insurance in 1998: • WSPS survey of the number of children with insurance in 1998. To estimate the number of children with insurance in 2000: • WSPS survey of the number of children with insurance in 2000. Progress Summary: The next WSPS should be completed in the fall of 2000.

[1] Listed as a performance goal in the state of Washington's CHIP Application to HCFA.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
	Increase the **percentage** of children below 200% FPL, who have health coverage [2].	Data Sources: Washington State Population Survey (WSPS). It is conducted every two years by the Office of Financial Management's (OFM) Forecasting section). Methodology: Compare the percentage of children with health insurance in 1998, to those had insurance in 2000. To estimate the percentage of children with insurance in 1998: • Numerator: Number of children with insurance in 1998 • Denominator: Number of children 1998. To estimate the percentage of children with insurance in 2000: • Numerator: Number of children with insurance in 2000 • Denominator: Number of children 2000. Progress Summary: The next WSPS should be completed in the fall of 2000.

[2] Listed as a performance goal in the State CHIP Application to HCFA.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO CHIP ENROLLMENT		
To increase the number of children in households between 200% and 250% of FPL who have health insurance coverage.	Increase the **number** of children between 200% and 250% of FPL who have health care coverage [3]	Data Sources: Washington State Population Survey (WSPS). It is conducted every two years by the Office of Financial Management's (OFM) Forecasting section). Methodology: Compare the number of children with health insurance in 1998, to those had insurance in 2000. To estimate the number of children with insurance in 1998: • WSPS survey of the number of children with insurance in 1998. To estimate the number of children with insurance in 2000: • WSPS survey of the number of children with insurance in 2000. Progress Summary: The next WSPS should be completed in the fall of 2000.

[3] Listed as a performance goal in the State CHIP Application to HCFA.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO CHIP ENROLLMENT		
	Reduce the **percentage** of uninsured children between 200% and 250% of FPL [4]	Data Sources: Washington State Population Survey (WSPS). It is conducted every two years by the Office of Financial Management's (OFM) Forecasting section). Methodology: Compare the number of children with health insurance in 1998, to those had insurance in 2000. To estimate the **percentage** of children with insurance in 1998: • Numerator: Number of children with insurance in 1998 • Denominator: Number of children 1998. To estimate the **percentage** of children with insurance in 2000: • Numerator: Number of children with insurance in 2000 • Denominator: Number of children 2000. Progress Summary: The next WSPS should be completed in the fall of 2000.

[4] Listed as a performance goal in the State CHIP Application to HCFA.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
	Track the satisfaction and health care of CHIP children compared to Medicaid children and non-Medicaid children [5]	Data Sources: Survey to be conducted in the winter of 2001, of enrollees, based upon their experience in 2000. The survey will use the national Consumer Assessment of Health Plan Survey (CAHPS). CHIP and Medicaid enrollees will be surveyed concurrently. Methodology: Compare CHIP enrollee satisfaction to Medicaid enrollee satisfaction on satisfaction with their personal doctor nurse, specialist, health care, and health plan. Numerator: Compare satisfaction levels between CHIP and Medicaid clients. Progress Summary: None. The survey will not be conducted until the winter of 2001. CHIP started on 2/1/2000.

[5] Listed as a performance goal in the State CHIP Application to HCFA.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
		Data Sources: MAA will contract with an external review organization to measure CHIP well child care rate using standard protocols for the Medicaid population. Methodology: Measure the percent of CHIP children who received age appropriate EPSDT exams during the reporting year. Numerator: The number of CHIP children who received EPSDT exams. Denominator: The number of CHIP children who were eligible to receive EPSDT exams. Progress Summary: None. CHIP started on 2/1/2000. Because EPSDT requires the child to have been continuously enrolled in their health plan for the prior 12 months, the measure cannot be obtained for 2000.

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

___ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

_X_ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program:

Washington State CHIP.

Date enrollment began (i.e., when children first became eligible to receive services):

February 1, 2000.

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Wraparound Benefit Package

Name of program: _____
Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

Not applicable

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

Not applicable

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

There are two programs discussed in this section: Medicaid, and the Basic Health Plan.

The Washington Department of Social and Health Services (DSHS) has been a national leader in expanding Medicaid coverage to children. In 1989, DSHS implemented its "First Steps Program" to improve birth outcomes. This included expanded Medicaid coverage to pregnant women and infants in households up to 185% of FPL. In 1991, children's health coverage was made available to all children up to age 18 residing in households with income up to 100% of FPL. This program was converted to Medicaid in 1992, and eligibility was expanded to include children up to age 19. In 1994, Medicaid coverage was expanded to 200% of FPL for children through age 18. Prior to the enactment of CHIP in 1997, Washington was one of only four states with Medicaid coverage at or above 200% of FPL.

Washington's Medicaid program serves over 730,000 people (this includes over 420,000 clients in managed care (i.e., Healthy Options)). Since our potential CHIP population is much smaller (about 15,000), we designed CHIP to look like our Medicaid program. This similarity will help ensure that clients who move from CHIP to Medicaid, or vice versa, will receive the same scope of benefits from the same providers. The most significant differences between CHIP and Medicaid programs are that CHIP:

- Requires families to pay monthly premiums and copayments;
- Children can lose their eligibility if the family fails to pay their monthly premiums for 4 months;
- Has two managed care plans, while Medicaid (under the Healthy Options program) has nine plans; and
- Children, who live in a county with two managed care plans [1], have 60 days to change plans. After this 60-day period "grace period", they are "locked- in". Children can choose a different plan at end of the calendar year when the new managed care plans are announced, or at their 12-month redetermination period. Medicaid's Healthy Options has no-lock in policy.

The Basic Health Plan (BHP) is administered by the state's Health Care Authority. It was implemented in 1988 to provide state subsidized health coverage to low-income persons. Until Medicaid was expanded to 200% of FPL in 1994, BHP offered subsidized coverage to children and their families up to 200% FPL. Today, there are approximately 80,000 Medicaid covered children whose parents receive subsidized coverage through the Basic Health Plan Plus (BHP +)

The Health Care Authority also has two other Basic Health Plan programs. One program is subsidized and the other is not. The subsidized program is for families with a gross income at or below 200% FPL and currently has approximately 131,000 enrollees. The non-subsidized program currently has about 7,000 enrollees.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

___ No pre-existing programs were "State-only"

_X_ One or more pre-existing programs were "State only" !Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

The non-subsidized Basic Health Plan program is not accepting new enrollees in 38 of the state's 39 counties. The subsidized plan is accepting enrollees and has no waiting list. Both of these programs serve children and adults. CHIP was not folded into any of the Health Care Authority's programs.

2.2.3 Describe changes and trends in the State since implementation of your Title XXI

[1] For service year 2000, there are three counties that have 2 managed care plans. Table 3.2.3 has more detailed information.

program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

CHIP started on 2/1/2000. There have been no changes to the Medicaid program, since implementation of CHIP.

___ Changes to the Medicaid program

- ___ Presumptive eligibility for children
- ___ Coverage of Supplemental Security Income (SSI) children
- ___ Provision of continuous coverage (specify number of months ___)
- ___ Elimination of assets tests
- ___ Elimination of face-to-face eligibility interviews
- ___ Easing of documentation requirements

___ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)_____

___ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

- ___ Health insurance premium rate increases
- ___ Legal or regulatory changes related to insurance
- ___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
- ___ Changes in employee cost-sharing for insurance
- ___ Availability of subsidies for adult coverage
- ___ Other (specify) _____

___ Changes in the delivery system

- ___ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
- ___ Changes in hospital marketplace (e.g., closure, conversion, merger)
- ___ Other (specify) _____

___ Development of new health care programs or services for targeted low-income children (specify) _____

___ Changes in the demographic or socioeconomic context
- ___ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)_____
- ___ Changes in economic circumstances, such as unemployment rate (specify)_____
- ___ Other (specify)_____
- ___ Other (specify) _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1

	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program**
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	NA	All 39 counties in the state are served by a combination of a managed care plan (plan) and/or fee-for-service (FFS) [1]; • 3 counties have 2 plans • 29 counties have 1 plan and FFS • 7 counties are FFS only	NA
Age	NA	0 up to age 19	NA
Income (define countable income) [2]	NA	The following are deducted from the parent's monthly income: • Work related child care or adult care; • $90 earned income credit for each working adult; and • Court ordered child support payments for a child living outside of the home. These are the same deductions used to determine Medicaid eligibility.	NA

[1] "Carve-out" or "wrap-around" services are available in all 39 counties. See Table 3.2.3.
[2] Refer to Attachment 3, Addendum to Table 3.1.1 for more detailed information on countable income.

Table 3.1.1			
	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program**
Resources (including any standards relating to spend downs and disposition of resources)	NA	No	NA
Residency requirements	NA	Child must be a resident. A resident is an individual who: a. Currently lives in Washington and intends to continue living here; or b. Entered the state looking for a job; or c. Entered the state with a job commitment. A person does not need to live in the state for a specific period of time to be considered a resident.	NA
Disability status	NA	NA	NA
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	NA	If a child has creditable coverage [3] at the time of application they are not CHIP eligible.	NA
Other standards (identify and describe)	NA	To be eligible for CHIP clients must: • Not have had employer-sponsored dependent coverage within 4 months of application [4] • Agree to pay premiums and copays (excluding AI/AN [5]) • Choose a managed care plan if they live in a county with two or more plans (excluding AI/AN)	NA

[3] Attachment 4 includes the definition of creditable coverage and gives examples of the types of coverage included and excluded in this definition for the purposes of determining CHIP eligibility.
[4] Refer to Attachments 2 and 3 for information on how this provision is applied.
[5] American Indian/Alaska Native

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Monthly	NA	No	NA
Every six months	NA	No	NA
Every twelve months	NA	Yes	NA
Other (specify)	NA	A CHIP child may become Medicaid eligible, if: • The family's income decreases below 200% FPL and they no longer want to pay CHIP premiums and copays, or • A child becomes pregnant.	NA

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

X Yes ≡ Which program(s)?

The state designed CHIP program.

For how long?

Children remain CHIP eligible for 12-months, unless:

- The family fails to pay CHIP premiums for 4-months;
- A CHIP child becomes Medicaid eligible (e.g., change in family income or family size, or CHIP child becomes pregnant); or
- A child reaches their 19th birthday during the 12 month eligibility period.

___ No

3.1.4 Does the CHIP program provide retroactive eligibility?

X Yes ≡ Which program(s)?

The state designed CHIP program, as noted below.

How many months look-back?

Children are eligible back to the first of the month in which the application was received. For example, if we receive an application in May, and eligibility is determined in June, we will cover care on a fee-for-service basis back to May 1. CHIP does not follow the Medicaid rules that allows 3-months of retro-eligibility.

___ No

3.1.5 Does the CHIP program have presumptive eligibility?
___ Yes ≡ Which program(s)?

Which populations?

Who determines?
X No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

_X_ Yes ≡ Is the joint application used to determine eligibility for other State programs? If yes, specify.

The same application is used for all the agency's children's medical programs. Children who are eligible for Medicaid are automatically eligible for the Women, Infant and Children (WIC) program as administered by the Department of Health (See Table 3. 5). Due to the higher income level, a child who is eligible for CHIP is not automatically eligible for other state programs.

___ No

3.1.7 Evaluate the strengths and weaknesses of your ***eligibility determination*** process in increasing creditable health coverage among targeted low-income children

Washington State's CHIP started on 2/1/2000. We have very limited experience making CHIP eligibility determinations as of this report's date.

3.1.8 Evaluate the strengths and weaknesses of your ***eligibility redetermination*** process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

Washington State's CHIP started on 2/1/2000. As of this report's date, there have been no redeterminations completed on CHIP families.

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

Table 3.2.1 CHIP Program Type: State Designed Program			
Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	✓	No	
Emergency hospital services	✓	$25 copay if the child is not admitted as an inpatient	
Outpatient hospital services	✓	No	
Physician services	✓	$5 copay, excluding visits with immunizations or well child checks	
Clinic services	✓	$5 copay, for visits with physicians, Advanced Registered Nurse Practitioners and Physician Assistants, excluding visits with immunizations or well child checks	
Prescription drugs	✓	$5 for non-generics	
Over-the-counter medications	✓	$5 for non-generics	
Outpatient laboratory and radiology services	✓	No	
Prenatal care	✓	No	
Family planning services	✓	No	
Inpatient mental health services	✓	No	Limited through Regional Support Networks (RSNs)
Outpatient mental health services	✓	No	Limited through Regional Support Networks (RSNs)
Inpatient substance abuse treatment services	✓	No	Limited through the Division of Alcohol and Substance Abuse (DASA)

Table 3.2.1 CHIP Program Type: State Designed Program			
Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Residential substance abuse treatment services	✓	No	Limited through the Division of Alcohol and Substance Abuse (DASA)
Outpatient substance abuse treatment services	✓	No	
Durable medical equipment	✓	No	
Disposable medical supplies	✓	No	
Preventive dental services	✓	No	
Restorative dental services	✓	No	
Hearing screening	✓	No	
Hearing aids	✓	No	
Vision screening	✓	No	
Corrective lenses (including eyeglasses)	✓	No	
Developmental assessment	✓	No	
Immunizations	✓	No	
Well-baby visits	✓	No	
Well-child visits	✓	No	
Physical therapy	✓	No	Limited under fee-for-service
Speech therapy	✓	No	Limited under fee-for-service

Table 3.2.1 CHIP Program Type: State Designed Program			
Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Occupational therapy	✓	No	Limited under fee-for-service
Physical rehabilitation services	✓	No	Limited under fee-for-service
Podiatric services	✓	No	
Chiropractic services	✓	No	
Medical transportation	✓	No	
Home health services	✓	No	
Nursing facility	✓	No	
ICF/MR	✓	No	
Hospice care	✓	No	
Private duty nursing	✓	No	Limited
Personal care services	✓	No	
Habilitative services	✓	No	
Case management/Care coordination	✓	No	Limited
Non-emergency transportation	✓	No	
Interpreter services	✓	No	

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

CHIP offers the same scope and range of health coverage and benefits as the Medicaid Categorically Needy Program (CNP).

Children with special health care needs have available preventative services including EPSDT and age appropriate immunizations. The requirements for managed care plans (plans) as they relate to special needs children include:

1) Plans must provide appropriate support services to assist practitioners in case management of members with chronic/high-risk illnesses. These services must include, but not be limited to:
   a) an effective mechanism to initiate services for inpatient and outpatient care, catastrophic incidents, and coordinated discharge planning;
   b) an effective mechanism to coordinate services required by members, including but not limited to transportation, Regional Support Networks for mental health services, developmental disability services, home and community services for older and physically disabled individuals, alcohol and substance abuse services, and services for children with special health care needs;
   c) individualized care plans developed for each member which ensure integration of the various clinical and non-clinical disciplines and services in the overall plan of care;
   d) a process to evaluate and improve the effectiveness of each member's case management services; and
   e) a process to evaluate the effectiveness of case management as a whole.

2) At a minimum, case management services must ensure:
   a) that practitioners are educated regarding the special needs of members who are aged, blind, and those disabilities;
   b) that practitioners reasonably accommodate the special needs of members who are aged, blind, and those with disabilities;
   c) that practitioners will assist members who are aged, blind, and those with disabilities to maximize their involvement and decision-making about the care they receive;
   d) that practitioners maximize all members' independence and functioning through health promotion and preventive care, and endeavor to reduce hospitalization through appropriate home care; and

e) that members are educated about appropriate emergency department use.

3) The plan must assure that their Primary Care Physicians (PCPs) are responsible for at least the following activities:
   a) Supervision, coordination, and provision of health care to meet the needs of each member. The PCP coordinates services to meet members' health care needs, including those to which the member may self-refer to participating providers for women's health care [1]. The PCP must provide or refer for all health services, including those not covered by the contract.
   b) Initiation and coordination of referrals for medically necessary specialty care. Appropriate referrals for community health and social programs, including but not limited to, First Steps Maternity Support Services and Maternity Case Management Services, are incorporated into health care protocols.

Enabling services are also available to CHIP children, as outlined below:

- Non-emergency transportation;
- Language interpretation;
- Home health visits;
- Outreach services to assist families to complete the children's medical application; and
- Translated materials in seven standard languages, plus other needed languages on request.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3

Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
A. Comprehensive risk managed care organizations (MCOs)	NA	___	NA
Statewide?	NA	___ Yes _X__ No 32 counties have at least 1 managed care plan. Of these counties: • 3 counties have 2 plans • 29 counties have 1 plan and FFS	NA

[1] As defined in the Revised Code of Washington (RCW) 48.42.100

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Mandatory enrollment?	NA	_X__ Yes ___ No • In 3 counties that have two plans. • Not for the counties with 1 plan.	NA
Number of MCOs	NA	There are two CHIP MCOs in the state	NA
B. Primary care case management (PCCM) program	NA	Only for AI/AN clients	NA
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	NA	X__ Yes ___ No CHIP clients will use the same contractors as used for Medicaid. There services are available in all 39 counties.	NA
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	NA	X__ Yes ___ No Health care providers who are qualified for reimbursement under Medicaid, are also qualified for reimbursement under CHIP.	NA

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

___ No, skip to section 3.4

_X Yes, check all that apply in Table 3.3.1

Table 3.3.1			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program *
Premiums	NA	Yes. Refer to section 3.3.2 AI/AN are excluded from cost sharing	NA
Enrollment fee	NA	No	NA
Deductibles	NA	No	NA
Coinsurance/copayments [2]	NA	Yes • $5 for office visits with Physicians [3], Advanced Registered Nurse Practitioners, and Physician Assistants (excluding visits with immunizations and well-child checks • $5 for non-generic drugs • $25 for use of the emergency room if the child is not admitted. AI/AN are excluded from cost sharing	NA
Other (specify): Limits on out-of-pocket costs?	NA	Yes. Refer to section 3.3.2	NA

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

CHIP premiums are $10 per child-per month, with a family maximum of $30 per month. Families with 4 or more children pay a maximum of $30 per month for CHIP premiums. The premiums are billed to the head of household every month and are payable to the department. American Indian/Alaska Native (AI/AN) are excluded from cost sharing.

[2] See Table 3.2.1 for detailed information.
[3] Includes ,doctors of medicine, osteopathy, or podiatry.

CHIP families receive billing statements every month, with a postage paid return envelope. The billing statement includes the new billing amount, and the amount, if any, that is overdue for 30, 60, 90 and 120 days. Bills are mailed on the 5th of every month and are due on the 20th of every month.

If a premium remains unpaid for 90 days, the family receives a separate notice stating that CHIP eligibility for all of their children will end if their premiums are overdue for 120 days. As noted in Table 3.1.1, families must agree to pay copays and premiums to be CHIP eligible. The separate notice informs family's that if they cannot afford to pay premiums due to a change in income they may be Medicaid eligible and should contact the department.

If the family fails to pay premiums that are owed we will prospectively terminate their CHIP eligibility at the end of the fourth full month that the premiums are overdue.

To reestablish CHIP eligibility, the family must pay owed premiums and serve a 4-month waiting (lock-out) period. Premiums that are owed for more than 12-months are forgiven and do not have to be repaid.

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

_X_ Employer
_X_ Family
_X_ Absent parent
_X_ Private donations/sponsorship
_X_ Other (specify)

We do not have the ability to track who pays CHIP premiums. The monthly statements are sent only to the head of household.

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

There are no CHIP enrollment fees.

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

There are no CHIP deductibles.

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

Families receive information on the cost-sharing requirements and maximum out-of-pocket costs through marketing and promotional materials, and through the client guide that is sent to families as part of the CHIP eligibility determination process. Individuals who have Internet access can

download the CHIP client guide and other CHIP related information through the CHIP Home Page (http://maa.dshs.wa.gov/CHIP).

As part of the eligibility determination process, families must agree to pay copays to providers and premiums to the department. If the family does not agree to cost-share, the children are not eligible for CHIP [4].

The maximum annual out-of-pocket costs for CHIP are:
- For one child, three hundred dollars;
- For two children, six hundred dollars; and
- For three or more children, nine hundred dollars.

The family maximum is nine hundred dollars. The family out-of-pocket maximum is calculated on a 12-month basis. The starting date for determining twelve-month out-of-pocket maximum expenses is the date that the first child in a family became eligible for CHIP services. For example, if a family has:

- One child, and that child became eligible for services on April first, the twelve-month period starts on April first;
- Two children, and the first child became eligible for services on April first and the second child started three months later on July first, the twelve-month period for both children starts on April first;
- Three or more children, and the first child became eligible for services on April first, and the last child became eligible on November first (within the same twelve-month period), the twelve-month period starts on April first for all the children.

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

X Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
___ Other (specify)_____

There are three methods used to ensure that a family's cost-sharing does not exceed 5 percent of their income. First, as part of the education process, outreach workers inform families about their responsibility to track costs and submit copay receipts to the department. Second, the CHIP Client

[4] Excluding American Indian and Alaska Natives.

Guide includes a sample worksheet and instructions on tracking their out-of-pocket costs. Third, the monthly (premium) billing statement has reminders on the need to track costs.

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

No families have reached the 5 percent cap. The CHIP program started on 2/1/2000.

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

We have not conducted an assessment of the effect of premiums on participation. CHIP started on 2/1/2000.

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (T=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

As of this report's date, we have very limited experience conducting client education and outreach for CHIP. Our Healthy Kids Now! campaign started with a governor's press conference on February 17, 2000. This campaign resulted in the largest one day response to any of any of our previous outreach efforts. Healthy Kids Now! is used to promote both CHIP and Medicaid. Washington's CHIP started on 2/1/2000.

Table 3.4.1						
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program	
	T = Yes	Rating (1-5)	T = Yes, we plan to do this in the future	Rating (1-5)	T = Yes	Rating (1-5)
Billboards	NA	NA	✓	Not known	NA	NA
Brochures/flyers	NA	NA	✓	Not known	NA	NA
Direct mail by State/enrollment broker/administrative contractor	NA	NA	✓	Not known	NA	NA
Education sessions	NA	NA	✓	Not known	NA	NA
Home visits by State/enrollment broker/administrative contractor	NA	NA	✓	Not known	NA	NA
Hotline	NA	NA	✓	Not known	NA	NA
Incentives for education/outreach staff	NA	NA	✓	Not known	NA	NA
Incentives for enrollees	NA	NA	No	Not known	NA	NA
Incentives for insurance agents	NA	NA	No	Not known	NA	NA
Non-traditional hours for application intake	NA	NA	✓	Not known	NA	NA
Prime-time TV advertisements	NA	NA	✓	Not known	NA	NA
Public access cable TV	NA	NA	✓	Not known	NA	NA
Public transportation ads	NA	NA	✓	Not known	NA	NA
Radio/newspaper/TV advertisement and PSAs	NA	NA	✓	Not known	NA	NA

Table 3.4.1						
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program	
	T = Yes	Rating (1-5)	T = Yes, we plan to do this in the future	Rating (1-5)	T = Yes	Rating (1-5)
Signs/posters	NA	NA	✓	Not known	NA	NA
State/broker initiated phone calls	NA	NA	✓	Not known	NA	NA

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (T=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Client education and outreach activities are done through outreach brokers at the local level. As of this report's date, we have very limited experience on the success of the client education and outreach approaches for CHIP. CHIP started on 2/1/2000.

Table 3.4.2						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program	
	T = Yes	Rating (1-5)	T = Yes, we plan to do this in the future	Rating (1-5)	T = Yes	Rating (1-5)
Battered women shelters	NA	NA	✓	Unknown	NA	NA
Community sponsored events	NA	NA	✓	Unknown	NA	NA
Beneficiary's home	NA	NA	✓	Unknown	NA	NA
Day care centers	NA	NA	✓	Unknown	NA	NA
Faith communities	NA	NA	✓	Unknown	NA	NA
Fast food restaurants	NA	NA	✓	Unknown	NA	NA
Grocery stores	NA	NA	✓	Unknown	NA	NA
Homeless shelters	NA	NA	✓	Unknown	NA	NA
Job training centers	NA	NA	✓	Unknown	NA	NA
Laundromats	NA	NA	✓	Unknown	NA	NA
Libraries	NA	NA	✓	Unknown	NA	NA
Local/community health centers	NA	NA	✓	Unknown	NA	NA
Point of service/provider locations	NA	NA	✓	Unknown	NA	NA
Public meetings/health fairs	NA	NA	✓	Unknown	NA	NA
Public housing	NA	NA	✓	Unknown	NA	NA

Table 3.4.2						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program	
	T = Yes	Rating (1-5)	T = Yes, we plan to do this in the future	Rating (1-5)	T = Yes	Rating (1-5)
Refugee resettlement programs	NA	NA	✓	Unknown	NA	NA
Schools/adult education sites	NA	NA	✓	Unknown	NA	NA
Senior centers	NA	NA	✓	Unknown	NA	NA
Social service agency	NA	NA	✓	Unknown	NA	NA
Workplace	NA	NA	✓	Unknown	NA	NA

.

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

CHIP started on 2/1/2000. The following information on outreach activities is based on what has been used for Medicaid outreach. Since children must be assessed for Medicaid eligibility, as a condition of determining CHIP eligibility, CHIP outreach has been blended into these efforts.

Background on Current Outreach Activities

In 1998, the Washington State Legislature authorized Medical Assistance Administration (MAA) to spend up to $3.9 million in enhanced federal matching funds for outreach to Medicaid eligibles. The project started in October, 1998.

Contracts

MAA has contracted with 31 community-based organizations covering 33 out of the state's 39 counties. Contractors include health districts, county social service departments and eight Indian tribes. MAA required contractors to submit applications that had to be approved before proceeding. After signing contracts, MAA provided local training to project staff on outreach strategies, eligibility criteria, and enrollment process. MAA is reimbursing contractors by paying a monthly set rate and paying a $20 incentive for each client a contractor helps enroll. The community contracts were scheduled to end March 31, 2000 when the authorizing federal legislation sunsetted. In November 1999, however, Congress lifted the sunset date, so MAA will be able to extend the outreach contracts to June 30, 2001, or until the enhanced federal funds are spend.

Contractors are required to:

- Identify people likely to be eligible for Medicaid coverage;
- Educate potential eligibles on the benefits of participating in the Medicaid program and eligibility requirements;
- Assist potential eligibles to complete application for Medicaid eligibility;
- Educate new Medicaid recipients on how to access services; and
- Assist new Medicaid recipients to select a Healthy Options health care plan that will best meet their needs.

Innovations

To facilitate rapid implementation of the project, MAA developed a web site where we posted general information, the project application, answers to questions submitted by potential

applicants and links to other sites. The web site can be reached at MAA's Home Page: http://maa.dshs.wa.gov. When you get to the MAA home page, click on "Client Outreach."

Following is a description of data we collected on outreach efforts during the period January – December 1999.

Data Sources

We used several discrete sources to track implementation of the Medicaid Outreach Project, including:

- Quarterly Reports – Contractors self-reported data on the numbers of people they contacted and assisted.
- Confirmed Healthy Options enrollments. Contractors helped many clients complete enrollment forms to select a Healthy Options plan. Most, but not all, contractors identified themselves on the enrollment form when submitted to MAA. When a client was eligible for enrollment, the contractor received a $20 enrollment fee. Because some contractors did not identify themselves, we recognize that the number of clients enrolled by an outreach program is greater than what was reported.
- Medicaid Caseload – We tracked the changes in Medicaid caseload and, more specifically, children's caseload for the period January – September 1999.
- Referral Agencies – the Medical Eligibility Determination Services tracked the number of agencies that helped clients submit an application for medical eligibility.

Quarterly Reports

Contractors submitted reports on their activities within 60 days of the end of each calendar quarter. Contractors tracked their own data and/or provided estimates, including:

- Number of clients who were contacted;
- Number of Medicaid applications completed; and
- Number of Healthy Options enrollment forms submitted.

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

Contractors use a variety of strategies to maximize outreach efforts statewide, including:

- Multimedia marketing with massive information dissemination;
- Collaboration with various community partners/advocates;
- Training partners in screening for children's medical applications; and
- Application sites at various locations in communities statewide.

All client outreach materials use ethnically diverse visuals and are available in 7 languages [1] that are representative of our diverse population. Additional languages are available on request.

Also, outreach brokers and their partners are community-based and are themselves culturally and ethnically diverse, to match our diverse clientele.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

CHIP did not start until 2/1/2000. As of this report's date we have very limited expertise in this area.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5

Type of coordination	Medicaid	Maternal and child health/WIC	School districts, school lunch programs
Administration	Yes, see # 1, 2	Yes, see # 2	Yes, see # 2
Outreach	Yes, see # 2	Yes	Yes
Eligibility determination	Yes, see # 2	Yes, see # 2	Yes, see # 2
Service delivery	Yes, see # 3	No	No
Procurement	Yes, see # 4	No	No
Contracting	Yes	No	No
Data collection	Yes, see # 5	No	No
Quality assurance	Yes, see # 5	No	No

[1] The seven languages are: Spanish, Vietnamese, Cambodian, Laotian, Chinese, Korean and Russian.

#1: The CHIP and Medicaid programs are administered by the same state agency, the Department of Social and Health Services (DSHS), Medical Assistance Administration (MAA).

#2: MAA, the Department of Health (DOH) and the Office of the Superintendent of Public Instruction (OSPI) work together to coordinate client referrals, project planning, data sharing, and outreach activities. CHIP is included in these coordinated efforts.

#3: CHIP clients in fee-for-service can access the same providers that are available to Medicaid clients. CHIP clients in managed care can access the same network of providers, as available to Medicaid clients who use the same managed care plans. (CHIP has 2 plans, while Medicaid has 9 plans).

#4: For service year 2001, we plan to use the same process to procure managed care services for both CHIP and Medicaid. Plans will not be required to submit a bid on CHIP, if they submit a bid for Medicaid.

#5: Managed care providers are required to submit the same type of data for both Medicaid and CHIP. Onsite audits will also be completed for CHIP and Medicaid MCOs.

3.6 How do you avoid crowd-out of private insurance?

The literature documents three different types of crowd-out [2]. These different types occur when:
1) Employers drop family health insurance coverage because public alternatives are available
2) Families drop employer-based family coverage in favor of more affordable coverage, and
3) Families do not take up employer-based family coverage and elect a pubic alternative instead

We use two strategies to avoid the type of crowd-out as described in #2 above. First, CHIP pre-enrollment materials state that a child may have to serve a 4-month waiting period, if the family dropped employer sponsored dependent coverage within 4 months of applying for CHIP. Second, the CHIP application process includes detailed questions on whether a family dropped employer-sponsored dependent coverage.

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

X Eligibility determination process:

X Waiting period without health insurance (specify)

[2] E. Shenkman and R Bucciarelli, Crowd-out: Evidence from the Florida Healthy Kids Program, *Pediatrics*, Vol 104, No 3, Sept 1999, 507 – 513

Only if the family dropped employer sponsored dependent coverage within 4 months of application. The exceptions to this policy are listed in Attachment 5.

___ Information on current or previous health insurance gathered on application (specify)

Information on previous health insurance is obtained prior to making a child CHIP eligible.

___ Information verified with employer (specify)
___ Records match (specify)
___ Other (specify)

___ Benefit package design:

___ Benefit limits (specify)
_X_ Cost-sharing (specify)

CHIP clients must pay premiums and copays as outlined in Section 3.3.

___ Other (specify)

___ Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify)

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

As of this report's date, we do not have information on crowd-out. CHIP stared on 2/1/2000. We will track how many children are required to serve a 4-month waiting period, because the family dropped employer-sponsored dependent coverage.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

As of this report's date, there were no children enrolled in CHIP. CHIP started on 2/1/2000.

Table 4.1.1 CHIP Program Type: State Designed Program

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	None	None	None	None	None	None
Age						
Under 1	None	None	None	None	None	None
1-5	None	None	None	None	None	None
6-12	None	None	None	None	None	None
13-18	None	None	None	None	None	None

Countable Income Level*						
At or below 150% FPL	NA	NA	NA	NA	NA	NA
Above 150% FPL	None	None	None	None	None	None
Age and Income						
Under 1						
At or below 150% FPL	NA	NA	NA	NA	NA	NA
Above 150% FPL	None	None	None	None	None	None
1-5						
At or below 150% FPL	NA	NA	NA	NA	NA	NA
Above 150% FPL	None	None	None	None	None	None
6-12						
At or below 150% FPL	NA	NA	NA	NA	NA	NA
Above 150% FPL	None	None	None	None	None	None
13-18						
At or below 150% FPL	NA	NA	NA	NA	NA	NA
Above 150% FPL	None	None	None	None	None	None
Type of plan						
Fee-for-service	None	None	None	None	None	None
Managed care	None	None	None	None	None	None
PCCM	None	None	None	None	None	None

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

As of this report's date, we do not know how many children had access to, or coverage by, health insurance prior to enrollment in CHIP. CHIP started on 2/1/2000.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

Washington currently covers 490,000 children in state subsidized health care programs. This represents 30% of the total state population of children. 467,000 of these children have coverage through the state's Medicaid program, 13,000 children are covered through MAA's program for children who do not meet Medicaid residence requirements, and 10,000 are children in the state's subsidized Basic Health Plan (BHP) who are not financed through Medicaid.

Washington has employed four strategies to provide health coverage to its children. This includes major Medicaid expansions; implementation of the state-subsidized Basic Health Plan, comprehensive health insurance reforms, and Medicaid outreach initiatives.

First, the Washington Department of Social and Health Services (DSHS) has been a national leader in expanding Medicaid coverage to children. In 1989, DSHS implemented its "First Steps Program" to improve birth outcomes. This included expanded Medicaid coverage to pregnant women and infants in households up to 185% of FPL. In 1991, children's health coverage was made available to all children up to age 18 residing in households with income up to 100% of FPL. This program was converted to Medicaid in 1992, and eligibility was expanded to include children up to age 19. In 1994, Medicaid coverage was expanded to 200% of FPL for children through age 18. Prior to the enactment of CHIP in 1997, Washington was one of only four states with Medicaid coverage at or above 200% of FPL.

Second, Washington implemented the Basic Health Plan (BHP) in 1988 to provide state subsidized health coverage to low-income persons. Until Medicaid was expanded to 200% of FPL in 1994, BHP offered subsidized coverage to children and their families up to 200%. Today, there are 80,000 Medicaid covered children whose parents receive subsidized BHP coverage.

Third, in 1993, Washington enacted legislation to implement comprehensive health reform. The goal of this legislation was to ensure that all residents had health coverage . Although major portions of the law were repealed in 1995, the state did retain comprehensive insurance reforms on limiting preexisting conditions to three-months and requiring health carriers to guarantee portability and re-issuance. Non-subsidized BHP coverage was implemented through the Health Care Authority (HCA) to offer group-rated coverage to individuals above 200% of FPL. Funding was provided to expand subsidized BHP coverage and to expand children's Medicaid coverage up to 200% of FPL. Currently, BHP is authorized to cover 133,000 people.

As a result of the first three strategies, Washington has a significantly lower uninsured rate than most other states. Based on the most recent data, only 7.8% of the state's children are without health insurance.

The fourth strategy in the effort to identify and enroll uncovered children includes several outreach efforts to publicize the availability of coverage. These efforts include: public notifications, such as posters and bus posters; contracting with several of the large county Health Districts to identify potential eligibles and assist them in applying for coverage; and educating Medicaid providers and health care plans.

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

As of this report's date, no children were disenrolled from CHIP. CHIP started on 2/1/2000.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

As of this report's date, there are no children who did not re-enroll at renewal. CHIP started on 2/1/2000.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Table 4.2.3						
Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total	NA	NA	None	NA	NA	NA
Access to commercial insurance	NA	NA	None	NA	NA	NA
Eligible for Medicaid	NA	NA	None	NA	NA	NA
Income too high	NA	NA	None	NA	NA	NA
Aged out of program	NA	NA	None	NA	NA	NA
Moved/died	NA	NA	None	NA	NA	NA
Nonpayment of premium	NA	NA	None	NA	NA	NA
Incomplete documentation	NA	NA	None	NA	NA	NA
Did not reply/unable to contact	NA	NA	None	NA	NA	NA

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

CHIP started on 2/1/2000. MAA has not yet developed strategies to ensure that children who disenroll, but are still eligible, re-enroll.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 $0

FFY 1999 $0

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1 CHIP Program Type: State Designed CHIP Program				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	$0	$0	$0	$0
Premiums for private health insurance (net of cost-sharing offsets)*	NA	NA	NA	NA
Fee-for-service expenditures (subtotal)				
Inpatient hospital services	$0	$0	$0	$0
Inpatient mental health facility services	$0	$0	$0	$0
Nursing care services	$0	$0	$0	$0
Physician and surgical services	$0	$0	$0	$0
Outpatient hospital services	$0	$0	$0	$0
Outpatient mental health facility services	$0	$0	$0	$0
Prescribed drugs	$0	$0	$0	$0
Dental services	$0	$0	$0	$0
Vision services	$0	$0	$0	$0
Other practitioners' services	$0	$0	$0	$0
Clinic services	$0	$0	$0	$0
Therapy and rehabilitation services	$0	$0	$0	$0
Laboratory and radiological services	$0	$0	$0	$0
Durable and disposable medical equipment	$0	$0	$0	$0

Table 4.3.1 CHIP Program Type: State Designed CHIP Program				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Family planning	$0	$0	$0	$0
Abortions	$0	$0	$0	$0
Screening services	$0	$0	$0	$0
Home health	$0	$0	$0	$0
Home and community-based services	$0	$0	$0	$0
Hospice	$0	$0	$0	$0
Medical transportation	$0	$0	$0	$0
Case management	$0	$0	$0	$0
Other services	$0	$0	$0	$0

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap?

Funding under the 10 percent cap was applied to the development of the premium billing and collection process. The amount available under the 10 percent cap was inadequate to fund all CHIP related start-up costs. As a result, all other start-up activities were financed with state only funds. These activities include:

- Programming changes to the eligibility and provider payment computer systems;
- Salary and benefits for one full-time project manager; and
- Supplies, materials, printing, mailing, travel, and other administrative overhead.

We have not yet made a claim for the federal match, because CHIP started on 2/1/2000. Once CHIP is operational, we start claiming our federal matching funds, starting with the FFY 98 funding.

What role did the 10 percent cap have in program design?

Due to the limited funding, we had to minimize the cost of developing and administering CHIP. One way we achieved this goal was to design CHIP so that it had the same benefits as the Medicaid Categorically Needy Program. This symmetry will make the transitions from CHIP to Medicaid, and vice versa, more transparent to the clients and providers. We also used the same process to determine eligibility for both Medicaid and CHIP, where possible.

Table 4.3.2						
Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total computable share	NA	NA	$0	$0	NA	NA
Outreach	NA	NA	$0	$0	NA	NA
Administration	NA	NA	$0	$0	NA	NA
Federal share						
Outreach	NA	NA	$0	$0	NA	NA
Administration	NA	NA	$0	$0	NA	NA

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

_X_ State appropriations
___ County/local funds
___ Employer contributions
___ Foundation grants
___ Private donations (such as United Way, sponsorship)
___ Other (specify) _____

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

Table 4.4.1			
Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Appointment audits	NA	MCO	NA
PCP/enrollee ratios	NA	MCO	NA
Time/distance standards	NA	MCO	NA

Table 4.4.1			
Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Urgent/routine care access standards	NA	MCO	NA
Network capacity reviews (rural providers, safety net providers, specialty mix)	NA	MCO	NA
Complaint/grievance/ disenrollment reviews	NA	MCO	NA
Case file reviews	NA	NA	NA
Beneficiary surveys	NA	MCO, FFS	NA
Utilization analysis (emergency room use, preventive care use)	NA	MCO, FFS	NA

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2			
Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Requiring submission of raw encounter data by health plans	NA	_X_ Yes ___ No	NA
Requiring submission of aggregate HEDIS data by health plans	NA	_X_ Yes ___ No	NA

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

We do not have information on the quality of care received by CHIP enrollees. CHIP started on 2/1/2000.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

We will have information from a Consumer Assessment of Health Plans Survey and EPSDT analysis by winter 2001. The analysis will be conducted by an external quality review organization. (Refer to our response to the evaluation measures in Table 1.3).

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and

immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Table 4.5.1

Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)	NA	MCO, FFS	NA
Client satisfaction surveys	NA	MCO, FFS	NA
Complaint/grievance/ disenrollment reviews	NA	MCO	NA
Sentinel event reviews	NA	NA	NA
Plan site visits	NA	MCO	NA
Case file reviews	NA	NA	NA
Independent peer review	NA	NA	NA
HEDIS performance measurement	NA	NA	NA
Other performance measurement (specify)	NA	NA	NA

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

We do not have information on the quality of care received by CHIP enrollees. CHIP started on 2/1/2000.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

We will have information from a Consumer Assessment of Health Plans Survey and EPSDT analysis by winter 2001. The analysis will be conducted by an external quality review organization. (Refer to our response to the evaluation measures in Table 1.3).

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

There are no reports evaluating access, quality, utilization, cost or satisfaction regarding CHIP enrollees. CHIP started on 2/1/2000.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

As part of the process to determine CHIP eligibility, information must be collected that is not needed to determine eligibility for other medical programs. For example, as part of the CHIP eligibility process, families must:

- Indicate whether a child has creditable insurance at the time of application,
- Indicate whether they dropped employer-sponsored dependent coverage within 4 months of making a CHIP application,
- Agree to pay CHIP premiums and copays, and
- Must choose a CHIP managed care plan.

As a way to collect this information, we added a step to the CHIP eligibility determination process. This additional step is taken after it is determined that the family income is too high for Medicaid, but is within the limits for CHIP. This step consists of sending the family a separate mailing [3]. If the family does not return the required information, they are not CHIP eligible.

Client advocates and others have told MAA that this second step is confusing. As a result of this feedback, we are exploring ways to eliminate this second step by adding CHIP information to the standard application for children's medical benefits.

5.1.2 Outreach

No comments at this time.

5.1.3 Benefit Structure

[3] This mailing includes the CHIP client guide, as described in Section 3.3.6.

As a best practice, we designed CHIP so that it would have the same benefits as the Medicaid Categorically Needy Program. We believe this will make the transitions from CHIP to Medicaid, and vice versa, more transparent to clients and providers.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

We know that client advocates and others want us to improve our method of managing families who have reached their out-of-pocket maximum. Our current procedure is to issue a letter to the family that they would show to providers. This letter indicates that the family is exempt from copays for a specified time period.

We want to explore options to make it easier for providers to identify those families who have reached their out-of-pocket maximum. For example, we want to evaluate opportunities to modify the medical identification card, or the (on-line) medical eligibility verification (MEV) system.

To make it easier for families to pay CHIP premiums, we will explore options such as allowing credit card payment, or allowing families to pay several months in advance.

One issue that we may need to revisit is the starting point for calculating the out-of-pocket costs. Our current policy is to use the client's month of CHIP eligibility as the start of the 12-month timeframe. We thought this policy would be less confusing to clients because their 12 months of continuous eligibility and 12 months of out-of-pocket costs would be consistent.

However, the managed care plans and fee-for-service providers have told us that our policy not to use a calendar year is confusing and should be changed. We do not know whether this issue will discourage plans from participating in the CHIP procurement for the 2001 service year.

5.1.5 Delivery System

CHIP has two managed care plans, in contrast to the Medicaid managed care program (Healthy Options) that has nine plans. For the 2001 service delivery period, we want to increase the number of plans available to CHIP clients, to be more consistent with the Healthy Options program.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

No comments at this time.

5.1.7 Evaluation and Monitoring (including data reporting)

No comments at this time.

5.1.8 Other (specify)

No comments at this time.

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

No comments at this time.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

Creditable Coverage

The federal law that prohibits children with "creditable coverage" from being made CHIP eligible is a constant source of confusion and frustration among those who apply for CHIP. We recommend that the rules for determining "creditable coverage" be simplified, or eliminated, for CHIP.

Crowd out

We do not believe that "crowd-out" for CHIP is any more significant than for Medicaid. We recommend that the HCFA's policy of requiring crowd-out policies for employer-sponsored dependent coverage be terminated or significantly scaled back. In order to maximize enrollment in CHIP and Medicaid, the program requirements should be as similar as possible.

Outreach

States should be able to use the currently available outreach funding for both Medicaid and CHIP. Since outreach activities reach potential Medicaid and CHIP families, it does not make sense to restrict the outreach funding to only potential Medicaid families.

10% Administrative Cap

The 10% administrative cap is inadequate to cover the actual costs of designing and implementing a new state program. It would make more sense to fund the up front administrative costs with federal matching funds.

Vaccines for Children

Stand-alone CHIP programs are prohibited from using the Vaccines for Children (VFC) program, yet they are required to provide immunizations based on the same standards. This puts stand-alone programs in a difficult position. In some states, commercial plans participating in CHIP follow other professional standards.

We recommend that stand-alone CHIP programs be able to determine which immunization periodicity schedule they will adopt. In Washington we use the schedule approved by ACIP, the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). We also urge HCFA to allow stand-alone programs access to the VFC program.

Attachment 1
Washington State Population Survey

CHILDREN'S 1998 HEALTH INSURANCE STATUS			
Family Income	**Insured**	**Uninsured**	**Total**
FPL	**Number**	**Number**	**Number**
0% - 200%	430,291	71,585	501,876
201% - 250%	160,485	14,335	174,820
251% - 300%	141,383	16,220	157,603
+301%	752,491	22,799	775,290
Total	1,484,650	124,939	1,609,589
FPL	**Percent**	**Percent**	**Percent**
0% - 200%	85.7%	14.3%	100.0%
201% - 250%	91.8%	8.2%	100.0%
251% - 300%	89.7%	10.3%	100.0%
+301%	97.1%	2.9%	100.0%
Total	92.2%	7.8%	100.0%

SOURCE: 1998 Washington State Population Survey (July 1999 Release)
NOTES:

(1) Children includes persons through age 18 years old. The child's age was as of the date of the survey interview (March/April 1998).
(2) Federal poverty level (FPL) was for calendar year 1997.
(3) Income was for the reporting household unit. The income data was for calendar year 1997. The income value was gross household income, and was not adjusted for CHIP or Medicaid "countable income" eligibility definitions, such as earned income disregards or child care allowances.
(4) Insurance status was as of the date (March/April 1998) the survey was conducted.
(5) Uninsured status was based upon individuals who reportedly were not covered by : employer or union; Medicare; Medicaid or other DSHS program; Basic Health Plan; military health care; Indian health services; bought by a household member; bought by someone outside the household; or other health care.
(6) OFM, The Urban Institute and other authorities believe the Bureau of the Census' Current Population Survey (CPS) and other survey data, including the 1998 Washington State Population Survey, undercount Medicaid enrollment, and therefore overstate low-income uninsured coverage rates.

1998 Washington State Population Survey
DATA REPORT

Office of Financial Management
Forecasting
SEPTEMBER 21, 1998

THIS REPORT PRESENTS the 1998 Washington State Population Survey (SPS). The SPS was designed to provide a profile of Washington residents between decennial censuses. It collected data on topics such as employment, work experience, income, education, in-migration, health, health insurance, commute pattern, computer ownership, and internet usage, in addition to basic demographics. The 1997 Washington State Legislature funded this survey.

The survey was designed by the Office of Financial Management (OFM) with consultation from a legislative staff advisory group and an extended SPS Network that consisted of more than 80 individuals from research organizations, state agencies, local governments, and higher education institutions. The survey was administered by the Washington State University Social and Economic Sciences Research Center (SESRC). It was designed to utilize the national Current Population Survey (CPS) structure and questions to the greatest extent possible.

A total of 7,279 households from two separate samples (the general population sample and the expanded sample) completed the telephone interview in spring of 1998. The response rate for the general population sample is 59 percent and for the expanded sample is 43 percent. The average interview time was approximately 22 minutes. The interview questions were translated into Spanish, Russian, Korean, and Vietnamese. Bilingual interviewers were hired to conduct interviews with households in which those languages were used.

The survey data underwent initial processing at SESRC. Additional processing was done at OFM. OFM also constructed weights based on its 1998 population estimates and constructed new variables based on existing data.

The SPS is a valuable complement to other reports and data resources concerning the state's population. However, it is not meant to replace any of these other efforts. Its strength lies in the combined information at the household level on a wide range of issues. For example, SPS enables us to assess the geographic distribution of poverty because it contains data on location and income at the household level. However, it does not replace the March CPS, which measures income statewide on a year to year basis, or the OFM estimates of county population. The SPS estimate of poverty will differ somewhat from the CPS estimate because the questions and sampling frame are not identical. The OFM estimates of population by county were used as control totals to convert the raw statistical results of the survey into a recognizable and useful portrayal of the population of Washington State.

Survey Design

Sample Design

POPULATION

The population for this survey consists of all households located within the geographic boundaries of Washington State. Because this was a telephone survey, only the households with telephones were potential subjects. However, the 1990 census shows that less than 4 percent of Washington households did not have telephones. Households on military compounds and other group quarters (such as student dormitories, prisons, and nursing homes) were also excluded from this survey.[1] Since there is no universal list of all the households as defined above from which a random sample can be obtained, SESRC used the random digit dialing (RDD) approach to obtain the required sample. The RDD approach is most commonly used to ensure equal probability of selection for each household with an activated telephone line, listed or not. The RDD sampling frame SESRC used was prepared by the Genesys Sampling Company.

SAMPLING

General Population Sample and Expanded Sample. Two separate samples were drawn for this survey. One was a random sample of all Washington State households (or the general population). The targeted number of completed interviews for the general population was 6,000. The second was an expanded sample of households in which the household head (or the person most knowledgeable about the household's finances) was African American, Asian, Hispanic, or Native American. This expanded sample of minority groups enables use of the data to make inferences about characteristics of all major population groups. When examining the entire state population, responses from the expanded sample will be weighted to represent the incidence of these groups in the general population. For each of the minority groups identified above, 400 interviews were targeted from both the general population sample and the expanded sample.

To control survey costs, SESRC recommended that the expanded sample be drawn only from the census tract regions containing the highest concentrations of each minority group. Since the RDD sample was inclusive of all state regions, it already provided a fair representation for each minority group. SESRC's approach for expanding the sample of these populations was to identify the top five to ten census tracts for each minority group and to obtain a sufficient quantity of telephone numbers to ensure completion of the desired 400 completed interviews for each minority group.

Regional Stratification. The general population sample is stratified into eight geographic regions based on county of primary residence. The target completion for each region was 750. This regional grouping considered the similarities of economic and population characteristics among the 39 counties in Washington State. It was the result of consultation with legislative and other advisory groups for the State Population Survey.

[1] See discussion of limitations.

Western Washington counties were grouped into five regions as follows:

Region 1: Island, San Juan, Skagit, Whatcom
Region 2: Clallam, Cowlitz, Grays Harbor, Jefferson, Klickitat, Lewis, Mason, Pacific, Skamania, Wahkiakum
Region 3: King
Region 4: Kitsap, Pierce, Snohomish, Thurston
Region 5: Clark

Eastern Washington counties were grouped into three regions as follows:

Region 6: Adams, Asotin, Chelan, Columbia, Douglas, Ferry, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Stevens, Walla Walla, Whitman
Region 7: Spokane
Region 8: Benton, Franklin, Yakima

Questionnaire Design

The initial draft of the questionnaire was based on the March CPS questionnaire. In addition to the CPS questionnaire, the OFM State Population Survey group also collected questions from other sources that were considered important for the subject areas mentioned earlier.

The initial draft was reviewed by a group of more than eighty individuals representing different entities. Their comments were collected and reviewed by OFM. Many of the recommendations were incorporated into the final draft. The final draft was then sent to SESRC which reviewed it again for logic flow and recommended changes accordingly. Further changes were recommended by SESRC after the pretest of 100 cases. These changes were mainly aimed at reducing the interview time.

II. Survey Administration

The survey was administered by SESRC. Before the full-scale fielding, a pretest of 100 cases was conducted. The full-scale fielding started on March 1, 1998. The interview phase was originally planned to last through the month of March. However, difficulties in meeting the expanded sample targets and the addition of three more languages (Russian, Korean, Vietnamese) caused the interview phase to extend into May. The average interview time was approximately 22 minutes.

Advance letter. To obtain full cooperation from the potential respondents, SESRC sent an advance letter to about 4,000 households to announce the survey and explain its purpose. The addresses of these households were generated by matching phone numbers with existing directories.

Interview languages. The interview script was translated into Spanish, Russian, Korean, and Vietnamese. Bilingual interviewers were hired to conduct the interviews with households in which those languages were used. The majority of these language cases were Spanish-speaking households.

Response Rates. A total of 7,279 households completed the interview. Response rates were calculated separately for the general population sample and the expanded sample. The Council of American Survey Research Organizations recommends a calculation method that involves a total account of the sample dispositions and an estimation of eligibles from non-contact cases. According to this calculation method, the response rate for the general population sample is 59 percent and for the expanded sample is 43 percent. A forthcoming technical report will discuss in detail the sample disposition and calculation of the response rates for this survey.

III. The Analysis Data File

The analysis data file consists of 202 variables which were either extracted from the original survey data file or constructed at OFM. In the analysis file, the data are arranged so that each person occupies a separate record. Thus, a household with five members has five records. The file contains 19,923 persons from 7,279 households.

Coding of some of the open-ended questions is still in progress. However, the most important open-ended questions in this survey – questions on industry and occupation – have been coded by specialists from the Labor Market and Economic Analysis Branch of the Employment Security Department.

The analysis data file is available in both SAS format and Excel format. It can be downloaded from the OFM Web-page for SPS. The URL address is http://www.wa.gov/ofm under Population/Data.

IV. Data Tabulations

The data tabulations are presented in two forms, one for categorical and one for continuous variables. The former is basically a frequency analysis and the latter a means analysis.

Each tabulation is weighted and the eight regional values are presented alongside the state value. Also, all tabulations include the variable name, variable label, and the universe for that variable. A subtitle indicates whether the variable is a person variable, a household or respondent-only variable, or a family variable.

A variable with a frequency analysis runs through at least two pages (indicated as Part 1 of 2 and Part 2 of 2). The first page lists the state value and the numbers for Regions 1 through 4. The second page lists the state total again and the numbers for Regions 5 through 8. The number of pages will increase by an increment of two depending on the number of data levels in a variable.

Under the state and region headings, the weighted frequency counts and percentages for each data level are listed. Other information in the frequency tables includes a maximum margin of error at the 95 percent confidence level for the state and for each of the eight regions.

Margin of Error. Caution should be used in interpreting tabulations that contain small values with a relatively large margin of error. Take for example the question: *In which state did you [the respondent] live one year ago, if not in Washington?* The weighted tabulation shows that a state total of 326 people lived in Iowa one year ago. They constituted about 0.6 percent of individuals who were reported to have moved to Washington from another state within the past year. However, the ±7.1 percent margin of error indicates that we are only reasonably confident that the true number of Iowans is somewhere between zero and approximately 700. A common practice to reduce the standard error in such situations is to combine the data levels with fewer categories. In this particular example, instead of individual states, regions can be created.

For each of the means analyses, the numbers for the eight regions and the state total are all listed on one page. This type of table includes the following statistics:

- Total non-missing observations
- Mean
- Minimum
- Maximum
- Median
- Total observations
- Total missing observations
- Sum of weights
- Lower limit of 95 percent confidence interval
- Upper limit of 95 percent confidence interval

It should be pointed out that because of extreme high values in some of the continuous variables, the mean tends to be skewed. In such cases, the median would be a better measure of the central tendency.

V. Limitations

Since this survey was a telephone survey, households without telephones were excluded. This non-coverage is, however, quite small. Statewide, the percent of households without telephones was less than 4 percent according to the 1990 census. While there exists the risk of systematically missing some people in a telephone survey, most researchers do not consider it a to be serious problem.[2] A forthcoming technical report will examine the difference between households with

[2] Folz, D.H. (1996). *Survey Research for Public Administration*. Thousand Oaks, CA: Sage.
Frey, J.H. (1989). *Survey Research by Telephone*. Newbury Park, CA: Sage.

and without telephones and recommend adjustment factors, if necessary, for variables in which non-coverage of non-telephone households presents a concern.

Another limitation common to all surveys is "non-responses." This refers to households that refuse to participate in the survey. The response rate in this survey is 59 percent for the general population sample and 43 percent for the expanded sample. The response rate for the general population is above average for this type of survey. However, the response rate for the expanded sample is lower than desired. As in all surveys, there is a potential distortion in the results if the characteristics of the non-responding households are systematically different than those of the responding households. A common practice to partially compensate for the non-response error is to post-stratify the survey based on known population characteristics,[3] which was done in this project.

An examination of the responses suggests that the degree of distortion due to non-responses is small. OFM examined frequencies, means, and medians of selected key variables in the data set and compared the results with alternative data sources. For example, wage data from the survey was compared with wage information from the state Unemployment Insurance System. In virtually all cases where survey data were compared with alternative data sources, the results were very similar. The issue of non-response and comparisons between survey results and alternative data sources for key variables will be discussed in a forthcoming technical report.

A third limitation in this survey is the difference between the design and the post-stratification with respect to group-quarters populations. While the design called for exclusion of group-quarters populations, in the post-stratification process, the group-quarters population could not be separated from the general population estimates. Thus, the survey data were weighted to the entire state population. This issue will also be addressed in a forthcoming technical report.

[3] Lavrakas, P.J. (1993). *Telephone Survey Methods: Sampling, Selection, and Supervision*. Newbury Park, CA: Sage.

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Bob Longman*	House
Gary Lowe	WA State Assoc. of Counties
Jim Mayfield	WA ST Institute for Public Policy
Jim Medina	OMWBE
David Merrifield	WWU
Gary Moore	L&I
Mike Moore	Cowlitz-Wahkiakum
Victor Moore*	House
Richard Morrill	UW
Fred Nick	UW
Tim Norris	ESD
Ellen O'Brien-Saunders	WTECB
Christie O'Loughlin	DOA
Desmond O'Rourke	Impact Center
Jan Olmstead	Gov.'s Exec. Policy Office
Glenn Olson	Clark County
Toby Olson	Comm. on Disability Issues
Tony Orange	Comm. on African-Amer. Affairs
Cedric Page	HECB
Dave Pavelchek	WTECB
Douglas Pedersen	
Rick Peterson*	House
Polly Phipps	Sentencing Guidelines Comm.
Tina Preston	WA Fed of State Employees
Jennifer Priddy	SPI
Gary Ray	DOT
Patricia Richards	DSHS
Manuel Romero	Comm. on Hispanic Affairs
Jane Rushford	DNR
Fred Saeger	WA Assoc. of County Officials
Eric Schnapper	UW
Jennifer Scott	Gov.'s Office of Indian Affairs
Bern Shanks	DFW
Scott Sherman	
David Schumacher*	Senate
Bob Sicko	Puget Sound Regional Council
Art Siegal	
Kriss Sjoblom	WA Research Council
R. Peggy Smith	DOC
Chang Mook Sohn	Office of the Forecast Council
Paul Sommers	Northwest Policy Center
Roy Standifer	DOP
Fred Stephens	Office of the Governor
Stephen Stockett	The Bon Marché
Ed Strozyk	SPI
Tom Sykes	HECB
Lucky Tedrow	WWU
Tim Triesch	Grays Harbor
Greg Weeks	
Mary Welsh	DOR
William Whitlow	Safeco
Vicki Wilson	HCA
Richard Yukubousky	Municipal Research Serv. Center

*Denotes Legislative Advisory Group

Attachment 3

Addendum to Table 3.1.1, Countable Income

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999.** Also, if the rules are the same for each program, we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups:	____Gross	_X_ Net	____Both	____ NA
Title XXI Medicaid SCHIP Expansion:	____Gross	___ Net	____Both	_X_ NA
Title XXI State-Designed SCHIP Program:	____Gross	_X_Net	____Both	____ NA
Other SCHIP program:	____Gross	___ Net	____Both	_X_ NA

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups:	Up to 200% of FPL for children under age 19.
Title XXI Medicaid SCHIP Expansion:	NA
Title XXI State-Designed SCHIP Program:	Over 200%, but less than 250% of FPL for children under age 19.
Other SCHIP program:	NA

3.1.1.3 Complete Table 1.1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)

Enter "Y" for yes, "N" for no, or "D" if it depends on the individual circumstances of the case.

Attachment 3

Addendum to Table 3.1.1, Countable Income

Table 3.1.1.3				
Family Composition	**Title XIX Child Poverty-related Groups**	**Title XXI Medicaid SCHIP Expansion**	**Title XXI State-designed SCHIP Program**	**Other SCHIP Program***
Child, siblings, and legally responsible adults living in the household	Yes	NA	Yes	NA
All relatives living in the household	No	NA	No	NA
All individuals living in the household	No	NA	No	NA

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded.
Enter "C" for counted, "NC" for not counted and "NR" for not recorded.

Table 3.1.1.4				
Type of Income	**Title XIX Child Poverty-related Groups**	**Title XXI Medicaid SCHIP Expansion**	**Title XXI State-designed SCHIP Program**	**Other SCHIP Program***
Earnings				
Earnings of dependent children	C	NA	C	NA
Earnings of students	NC	NA	NC	NA

Attachment 3

Addendum to Table 3.1.1, Countable Income

Table 3.1.1.4				
Type of Income	**Title XIX Child Poverty-related Groups**	**Title XXI Medicaid SCHIP Expansion**	**Title XXI State-designed SCHIP Program**	**Other SCHIP Program***
Earnings from job placement programs	C	NA	C	NA
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	NC	NA	NC	NA
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	NC	NA	NC	NA
Education Related Income Income from college work-study programs	NC	NA	NC	NA
Assistance from programs administered by the Department of Education	NC	NA	NC	NA
Education loans and awards	NC	NA	NC	NA
Other Income				
Earned income tax credit (EITC)	NC	NA	NC	NA
Alimony payments received	C	NA	C	NA
Child support payments received	C	NA	C	NA
Roomer/boarder income	C	NA	C	NA

Attachment 3

Addendum to Table 3.1.1, Countable Income

Table 3.1.1.4				
Type of Income	**Title XIX Child Poverty-related Groups**	**Title XXI Medicaid SCHIP Expansion**	**Title XXI State-designed SCHIP Program**	**Other SCHIP Program***
Income from individual development accounts	NA	NA	NA	NA
Gifts [1]	C	NA	C	NA
In-kind income	C	NA	C	NA
Program Benefits				
Welfare cash benefits (TANF)	NC	NA	NC	NA
Supplemental Security Income (SSI) cash benefits	NC	NA	NC	NA
Social Security cash benefits	C	NA	C	NA
Housing subsidies	NC	NA	NC	NA
Foster care cash benefits	NC	NA	NC	NA
Adoption assistance cash benefits	NC	NA	NC	NA
Veterans benefits	C	NA	C	NA
Emergency or disaster relief benefits	NC	NA	NC	NA
Low income energy assistance payments	NC	NA	NC	NA

[1] Per Washington Administrative Code 388-450-0065, Cash gifts up to thirty cumulative dollars per calendar quarter, per individual, are disregarded as income.

Attachment 3

Addendum to Table 3.1.1, Countable Income

Table 3.1.1.4				
Type of Income	**Title XIX Child Poverty-related Groups**	**Title XXI Medicaid SCHIP Expansion**	**Title XXI State-designed SCHIP Program**	**Other SCHIP Program***
Native American tribal benefits	NC	NA	NC	NA

3.1.1.5 What types and *amounts* of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes _X_ No

If yes, please report rules for applicants (initial enrollment).

Table 3.1.1.5				
Type of Disregard/Deduction	**Title XIX Child Poverty-related Groups**	**Title XXI Medicaid SCHIP Expansion**	**Title XXI State-designed SCHIP Program**	**Other SCHIP Program***
Earnings	$90	NA	$90	NA
Self-employment expenses	Actual business expenses	NA	Actual business expenses	NA
Alimony payments		NA		NA

Attachment 3

Addendum to Table 3.1.1, Countable Income

Table 3.1.1.5				
Type of Disregard/Deduction	**Title XIX Child Poverty-related Groups**	**Title XXI Medicaid SCHIP Expansion**	**Title XXI State-designed SCHIP Program**	**Other SCHIP Program***
• Received • Paid	• Actual amount • NA		• Actual amount • NA	
Child support payments • Received • Paid	• Actual amount • Court ordered amount	NA	• Actual amount • Court ordered amount	NA
Child care expenses	Actual amounts	NA	Actual amounts	NA
Medical care expenses	NA	NA	NA	NA
Gifts [2]	Up to $30 is disregarded	NA	Up to $30 is disregarded	NA

3.1.1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups: _X__No ____Yes (complete column A in 3.1.1.7)

Title XXI SCHIP Expansion program: NA

Title XXI State-Designed SCHIP program _X__No ____Yes (complete column C in 3.1.1.7)

Other SCHIP program_____ NA

[2] Per Washington Administrative Code 388-450-0065, Cash gifts up to thirty cumulative dollars per calendar quarter, per individual, are disregarded as income.

Attachment 3

Addendum to Table 3.1.1, Countable Income

3.1.1.7 How do you treat assets/resources?

Please indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for vehicles. If not applicable, enter "NA."

Table 3.1.1.7 **Treatment of Assets/Resources**	**Title XIX Child Poverty-related Groups (A)**	**Title XXI Medicaid SCHIP Expansion (B)**	**Title XXI State-designed SCHIP Program (C)**	**Other SCHIP Program* (D)**
Countable or allowable level of asset/resource test	NA	NA	NA	NA
Treatment of vehicles: Are one or more vehicles disregarded? *Yes or No*	NA	NA	NA	NA
What is the value of the disregard for vehicles?	NA	NA	NA	NA
When the value exceeds the limit, is the child ineligible("I") or is the excess applied ("A") to the threshold allowable amount for other assets? *(Enter I or A)*	NA	NA	NA	NA

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? ___ Yes _X_ No

Attachment 4

Definition of Creditable Coverage

Proposed Administrative Rules
Defining Creditable Coverage

"Creditable coverage" means most types of public and private health coverage, except Indian Health Services, that provides access to physicians doctors, hospitals, laboratory services, and radiology services. This applies regardless of whether the coverage is equivalent to that offered under CHIP. "Creditable coverage" is more completely defined in 42 United States Code (USC) 1397jj.

Administrative Policies Used to Determine What Types of Creditable Coverage are Used to Determine CHIP Eligibility

The following table lists how various types of health coverage are defined and when the 4-month waiting period applies (for the purposes of determining CHIP eligibility).

Type, or Source, of Coverage	Creditable Coverage (1)	Employer Sponsored Dependent Coverage	4-Month Waiting Period
Coverage obtained through an employer, or union	Yes	Yes	Yes
COBRA	Yes	Yes	Yes
Group health plans	Yes	Depends on coverage	Depends on coverage
Individual coverage	Yes	No	No
Washington State Health Insurance Pool (WSHIP) (2)	No	No	No
Health Care Authority's Basic Health Plan, or Basic Health Plus (2)	No	No	No
Coverage for a single disease (e.g., cancer) (2)	No	No	No
Coverage for a specific service (e.g., dental or vision care) (2)	No	No	No
Medical coverage through auto insurance (2)	No	No	No
Coverage for accidents occurring at school (e.g., playground or sports)(2)	No	No	No
Indian Health Services (2)	No	No	No

Notes:
1. Creditable coverage means coverage that provides access to physician, hospital, radiology and laboratory services.
2. Although the types of coverage listed here may meet the creditable coverage definition, they are not considered to be creditable coverage for the purposes of determining CHIP eligibility.

Attachment 5

Proposed Administrative Rules

Defining the Waiting period for CHIP Coverage Following Employer Sponsored Dependent Coverage

Proposed Administrative Rules

(1) If the client or family chooses to end employer-sponsored dependent coverage, the client must serve a waiting period of four, full, consecutive months before becoming eligible to enroll in CHIP. The waiting period begins the day after the coverage ends, and ends on the last day of the fourth, full, month of non-coverage by the employer.

(2) MAA does not require a waiting period prior to CHIP coverage when:

- The client or family member has a medical condition that, without treatment, would be life-threatening or cause serious disability or loss of function; or
- The loss of employer sponsored dependent coverage is due to any of the following

(i) Loss of employment through which the coverage was offered;
(ii) Death of the employee;
(iii) The employer discontinues employer sponsored dependent coverage;
(iv) The family's total out-of-pocket maximum for employer sponsored dependent coverage is fifty dollars per month or more;
(v) The plan terminates employer sponsored dependent coverage for the client because the client reached the maximum lifetime coverage amount;
(vi) Coverage under a COBRA extension period expired;
(vii) Employer sponsored dependent coverage is not reasonably available (e.g., client would have to travel to another city or state to access care); or
(viii) Domestic violence that leads to loss of coverage for the victim.